

Washington State Board of Pharmacy P.O. Box 47863 Olympia, WA 98504-7863 (360) 236-4842

## Preceptor Evaluation and Certification of Experience

This form must be submitted to the Board office at the completion of the internship experience. If the internship experience exceeds twelve (12) months, it is recommended that this form be filed annually.

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NAME OF INTERN		YEAR IN SCHOOL
INTERN STREET ADDRESS		
CITY	STATE	ZIP
NAME OF PRECEPTOR		L
NAME OF INTERNSHIP SITE		
STREETADDRESS		
CITY	STATE	ZIP
Preceptor Evaluation of In  Briefly describe the type of professional experience received under your superv		
tion skills, accuracy, professional attitude, dispensing skills, ability to evaluate a pharmacy management. Also, pursuant to WAC 246-858-070(3), provide your a pharmacy at this stage of his or her internship. Attach an additional sheet(s) if r	assessment of t	
SIGNATURE OF PRECEPTOR	1	DATE

For The Two Week Period Of		For The Two Week Period Of					
From (Sunday)	To (Saturday)	Hours	From (Sunday)	To (Saturday)	Hours		
			Total Internship Hours				
Note: Internship hours will not be accepted after the signature date.							
	Preceptor	Certifica	ation of Experience	ce			
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I, certify that I am a pharmacist licensed in the							
State of and the above named intern practiced							
pharmacy under my supervision at pharmacy, or under a special internship							
program. I certify that the intern has completed goals set forth in the Washington State Board of Pharmacy Experiential							
Training Manual, the hours here recorded are correct, and to the best of my knowledge, the experience gained by the intern							
has been predominantly related to the practice of pharmacy as required by law.							
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PRECEPTOR'S SIGNATURE			DATE	LICENSE NO.			